patients for which fee-for-service reimbursement is available as determined by the Department of Health.

86-2.10 Computation of basic rate.

(j) Rates for residential health care facility services for nonoccupants for 1986 and subsequent rate years shall be calculated in accordance with section 86-2.9 of this Subpart, with any operating component of the rate trended from the 1983 base year, to the rate year by the applicable roll factor promulgated by the department.

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Outpatient Hospital Mental Health Services	
Intensive Day Treatment Program (programs certified by OMH pursuant to 14 NYCRR Part 581)	In accordance with the State Mental Hygiene Law, the Office of Mental Health establishes Medicaid rates of reimbursement for outpatient programs issued operating certificates by the Office. The Intensive Day Treatment program is an outpatient program. Medicaid rates established by the Office of Mental Health must be certified by the Commissioner and approved by Division of the Budget. The methods and standards set forth below do not apply to any other type of outpatient programs licensed by the Office of Mental Health:

TN# 87-31
Supersedes TN# _____

Approval Date OCT. 28 1988 Effective Date JUL. 1 19

(1) Operating Costs

Medicaid rates for Intensive Day Treatment programs are established prospectively and are all inclusive, taking into account all allowable costs and all allowable visits.

Because Intensive Day Treatment programs have not yet accumulated sufficient cost information to establish cost related rates, operating costs for all Intensive Day Treatment programs are determined on the basis of cost projections contained in budget documents prepared by Intensive Day Treatment programs selected for operation and submitted for review and approval by the Office of Mental Health.

Allowable operating costs include the costs of services approved by the Commissioner. In determining allowability of costs, the Office of Mental health reviews the categories of costs, described below, with consideration given to the special needs of the patient population to be served by the Intensive Day Treatment program. The categories of costs to be reviewed shall include, but not be limited to, the following:

(i) Clinical care. This category of cost includes salaries and fringe benefits for clinical and direct care staff of the program.

(ii) Other than clinical care. This category of cost includes costs associated with administration, maintenance and support expenses.

Allowable operating costs in the category of clinical care are limited to costs approved by the Commissioner in connection with his review of the Intensive Day Treatment programs staffing plan. Allowable operating costs in the category other than clinical care are limited to budgeted costs. The other than clinical costs reported will be reviewed to determine their relative impact within a given program, as well as in comparison to the universe of selected Intensive Day Treatment programs.

Appeals from rate determinations are heard by the Commissioner. The Commissioner may hear requests for rate revisions which are based on errors in the calculation of the rate or in the data submitted by the facility or based on significant changes in operating costs resulting from changes in services, programs or capital projects approved by the Commissioner in connection with the Office of Mental Health's certificate of need procedures. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

(2) Capital Costs

To allowable operating costs are added allowable capital costs. Allowable capital costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. A return on equity, as determined by the New York State Department of Health, is allowed for proprietary hospitals. To be allowable, capital expenditure subject to the Office of Mental Health's certificate of need procedures must be reviewed and approved by the Office of Mental Health.

OFFICIAL

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Ambulatory Services in Facilities Certified Under Article 31 of the State Mental Hygiene Law:	
OMH Clinic, Day and Continuing Treatment Programs	Flat fee developed by OMH and approved by the Division of the Budget.
Intensive Day Treatment Program (programs certified by OMH pursuant to 14 NYCRR Part 581)	[same as that for Intensive Day Treatment Program services under "Outpatient Hospital Mental Health Services"]

TN# 87-31
Supersedes
TN# ———

Approval Date OCT. 28 1988 Effective Date JUL 1 1987

OFFICIAL

Types of Service	Method of Reimbursement
Hospice Services: Routine Home Care Continuous Home Care Inpatient Respite Care General Inpatient Care (NOTE: "TEXT IN BRACKETS IS DELETED")	[Payment for hospice care will be in the same amounts and using the same methodology as used under Part A of Title XVIII. The four Medicare rates: general inpatient, inpatient, inpatient respite, routine home care and continuous home care, will be used by Medicaid for reimbursing each hospice provider.] Medicaid payment for hospice care will be in amounts no lower than the Medicare rates for: general inpatient, inpatient respite, routine home care and continuous home care using the same methodology as used under Part A of Title XVIII. Annual adjustments shall be made to these rates commencing October 1, 1990 using inflation factors developed by the State. For persons residing in nursing facilities who have elected hospice care, the Medicaid State agency will pay the hospice an amount sufficient to cover room and board as defined in Section 1905 (o) of the Social Security Act.
Special Needs Patients	Enhanced Medicaid rates for services to special need hospice patients are established for routine home care, continuous home care and general inpatient care using the following methodology: Use the percentages for each service component as promulgated by HCFA in the routine home care, continuous home care and general inpatient care rates, to determine service component dollar values;

TN 90-24 Approval Date MAY 1 1992

Supersedes TN 86-14 Effective Date APR 1 - 1990

OFFICIAL

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Special Needs Patients (cont.)	Use documented cost data which supports specific service component enhancement to calculate amount to be added to rate as an enhancement; Apportion each rate into its respective labor and non-labor component using the Medicare prescribed labor to non-labor ratios; Adjust labor component of each enhanced rate to account for regional differences in wages using Medicare hospice wage indices; Add adjusted labor component to the non-labor component to arrive at the regional enhanced rates.
Rehabilitative Services	The New York State Division of Alcoholism and Alcohol Abuse establishes rates of reimbursement for the provision of rehabilitative services to persons in freestanding alcoholism residential facilities. Allowable base year costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. To be allowable, costs must be reasonable and relate to patient care. Allowable costs may not include costs for services which have not been approved by the Director. Total allowable costs are classified as either treatment related costs or room and board related costs. Utilizing only allowable treatment related costs, a provider-specific Medicaid treatment rate shall be established. The treatment rate shall consist of an operating and a capital component.

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Rehabilitative Services	(1) Directly Observed Therapy (DOT) The New York State Department of Health establishes a weekly fee for the provision of Directly Observed Therapy. Fees are established to take into account service site, service complexity, service intensity, any existing relationship between the provider and the recipient, record of compliance and completion of therapy. Access to these fees will be available only to those providers who sign Provider Agreements.
Rehabilitative Services	For Freestanding out-patient providers, the Office of Mental Retardation and Developmental Disabilities will utilize established statewide cost related flat clinic fees for off-site services. Fees will be assigned based on provider specific clinic costs or budgets which correspond to the fiscal cycle of the provider. All fees are subject to the approval of the New York State Division of the Budget. Access to these fees will be available only to those providers who enter into Provider Agreements.

TN 92-54 Approval Date DEC 23 1992
Supersedes TN 92-10 Effective Date SEP 24 1992

N.Y. OFFICIAL

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Rehabilitative Services	**School Supportive Health Services**

Physical Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Occupational Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Speech Pathology Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated

Rehabilitative Services
(continued)

with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Nursing Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.

Psychological Counseling Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.

N.Y.

OFFICIAL

Rehabilitative Services
(continued)

Psychological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Transportation Services

The transportation fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the fee.

Audiological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Medical Evaluations

The medical evaluation fee and specialized medical evaluation fee are fee-for-service and are made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee. The specialized medical evaluation fee is reimbursable only when the service is provided by a physician specialist subsequent to and upon the written recommendation of the provider of a medical evaluation.